BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against: UBAH AHMED MINDINGALL 38936 WONDERING LANE MURRIETA, CA 92562 Respondent.	Case No. 2007-22 OAH No. L2006100309

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on September 27, 2007.

IT IS SO ORDERED August 27, 2007.

LaFrancine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against: UBAH AHMED MINDINGALL 38936 Wondering Lane Murrieta, CA 92562 Respondent.	Case No. 2007-22 OAH No. L2006100309

PROPOSED DECISION

On April 30, 2007, in San Diego, California, Alan S. Meth, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Rita M. Lane, Deputy Attorney General, Office of the Attorney General, represented complainant.

John Dratz, Attorney at Law, represented respondent.

The matter was submitted on June 11, 2007.

FACTUAL FINDINGS

1. On July 18, 2006, Ruth Ann Terry, M.P.H., R.N., Executive Officer, Board of Registered Nursing of the State of California (Board), filed Statement of Issues No. 2007-22 in her official capacity. Respondent filed a timely Notice of Defense.

After the hearing was completed, the parties filed closing briefs. Complainant's Closing Brief was marked Exhibit 14 and her reply brief was marked Exhibit 15. Respondent's Closing Brief was marked Exhibit H and her reply brief was marked Exhibit I.

2. On June 10, 2001, respondent signed an Application for RN Licensure by Endorsement and submitted it to the Board. By letter dated August 4, 2004, the Board informed respondent that it denied her application for licensure by examination as a registered nurse based upon its determination that respondent, while working as a registered

nurse at Sharp Memorial Hospital (Sharp) in San Diego under a temporary license, had committed unprofessional conduct and gross negligence in connection with her care and treatment of one patient. The Board also terminated respondent's temporary license and ordered her to return the original temporary license immediately. Respondent through her attorney submitted a written request for a hearing by letter dated October 4, 2004. On February 1, 2005, her attorney wrote to the Board asking for a status update and pointed out Business and Professions Code section 487 required the Board to conduct a hearing within 90 days of respondent's request for a hearing. Her attorney asked the Board to take immediate action to set a hearing date or reverse the denial of the license.

3. Respondent was first hired by Sharp on June 26, 2001 as a certified nurse assistant. After she applied for her license, she received a temporary license from the Board. She was then hired as a registered nurse.

In March 2002, respondent was working on the ninth floor north providing care to post-surgery patients. Mary J. was one of the patients on the floor. On March 13, 2002, Mary J.'s doctor ordered that she receive Ativan, one milligram IV every eight hours, and that she receive six doses, with the first dose to be administered immediately. Ativan is a medication used to treat anxiety. Nurses administered Ativan to Mary J. over the next two days, with the sixth and final ordered dose administered at 1:00 a.m. on March 15.

Respondent administered a seventh dose of Ativan at 8:30 a.m. on March 15. There was no physician's order in the chart authorizing the administration of Ativan at that time. At 11:30 a.m., Mary J.'s physician ordered the administration of Ativan, one milligram by mouth as needed.

4. Sharp has a written procedure it calls "Fall Prevention," with the stated purpose "To provide guidelines for patient assessment, planning, implementation, documentation, and evaluation for fall prevention." Sharp defines a fall as a "sudden unexplained change in position in which a patient comes to rest unintentionally on the floor (whether assisted or unassisted)." Sharp defines a "Schmid Falls Risk Assessment Tool" as "A tool that quantifies the degree of risk for falls based on five areas associated with risk (mobility, mentation, elimination, prior fall history, and medications.)"

Sharp requires a registered nurse to perform a Schmid Falls Risk Assessment upon admission of a patient and where there is a change in the patient's condition to assess the patient's risk for fall using the Schmid Falls Risk Assessment Tool and document the score and other fall risk variables in appropriate documentation location and indicate if the patient is at a high risk for fall. The standard of care placed upon a registered nurse also requires a registered nurse to perform a risk assessment for a fall.

Mary J. had been admitted to Sharp for right knee replacement surgery and placed in respondent's care on March 12. Respondent did not perform a Schmid Falls Risk Assessment after surgery as required by Sharp procedures and the standard of care.

On March 15, while still a patient at Sharp, Mary J. fell on the floor. Respondent failed to perform an appropriate post fall assessment and properly chart her assessment in the nursing notes. An entry on what appeared to be a worksheet did not satisfy the requirement for a post fall risk assessment to be placed in the patient's chart.

5. Miyo Minato, M.N., R.N., testified as the Board's expert in this matter. She has served as a nursing education consultant for the Board for seven years and was well-qualified to render an opinion as to whether respondent's care and treatment of Mary J. constituted gross negligence.

Ms. Minato testified that respondent's failure to perform a risk assessment of Mary J. following surgery and again after she fell, and her administration of an unauthorized dose of Ativan, collectively constituted gross negligence. Her testimony emphasized the pattern of poor nursing shown by her poor documentation and administration of an unauthorized medication. That testimony is supported by the evidence and is persuasive. Respondent offered no evidence to the contrary. Respondent's conduct could have injured the patient. A patient clearly can be harmed if given too much medication, and it was not for respondent to determine if a seventh dose was needed—the patient's doctor made that determination when he ordered only six dosages. Respondent's failure to perform the appropriate risk assessments resulted in the failure to appropriately plan for the patient's safety.

6. Respondent is 38 years of age, married, and has four minor children. They live with her in Missouri while her husband, a United States Marine, is stationed at Camp Pendleton, California. Respondent was born in Somalia and moved to the United Arab Emirate, where she attended high school and a professional nursing school. She obtained the equivalent of a license as a registered nurse in 1988 and worked as an RN for six and one-half years. She came to the United States in 1995 and obtained an RN license in Maryland after she passed a licensing examination. She worked as a CNA in Maryland before she received her license but did not work as an RN because she and her family moved to California.

Respondent submitted her application to the Board for licensure, which received it on June 26, 2001. She applied for a job at Sharp and was hired a week earlier as a CNA. The Board then issued a temporary license to respondent, and she began working at Sharp as an RN. Respondent remained at Sharp until September 22, 2003, when she moved to Murrieta and began working at the Hemet Valley Medical Center. She continued to work at Hemet Valley until August 2004, when the Board denied her application and terminated the temporary license.

In 2005, respondent's husband was transferred to a base in Missouri, and respondent and her family moved there with him. Respondent obtained an RN license and began working for Kindred Healthcare. Her license is valid through April 30, 2009. Respondent has enrolled in a BSN program through Webster University but has not taken any courses.

7. Respondent testified that in connection with her administration of the unauthorized dose of Ativan, she made a mistake. She had no explanation and testified that

she did not look at the order. As for the fall, respondent testified she told the patient's doctor about it and he said he would be in to examine her.

8. Respondent's supervisor at Sharp prepared a performance appraisal of respondent's work on June 3, 2002. Most areas evaluated showed a need for improvement. Her supervisor observed that respondent "need[ed] a great [sic] on encouragement and guidance in the clinical setting." Sharp determined that respondent's annual performance did not support a pay increase.

On October 1, 2002, respondent's manager on 9 North, Kathleen Holt, wrote a memorandum entitled "Formal Corrective Action—Written warning related to the continuation of nursing errors resulting in unsafe patient care." Ms. Holt described the history of coaching respondent had received over the course of the previous year, and provided "a partial list of errors/mistakes that [had] been brought to [respondent's] attention over the past 12 months." Many of the errors related to improper documentation and administration of medications. Ms. Holt created a system for respondent to correct her mistakes, a timeframe, and follow-up. Respondent then took a leave of absence for several months.

A "Per Diem RN Performance Evaluation—Annual" contained in respondent's personnel file dated June 13, 2003, indicated respondent met standards in all rated areas except one, where she needed improvement. The evaluation noted respondent had received a commendation. Respondent remained at Sharp for another three months until she left voluntarily.

9. Respondent submitted an Employee Annual Performance Review Form dated September 27, 2006 from Kindred Healthcare. The review indicated respondent generally met or exceeded standards in the areas rated, and her overall performance met hospital standards. In a box entitled "Job Description," the evaluator wrote:

> "[Respondent] provides good care to her patients. Completes admission assessments and reassessments in a timely manner. Follows policies and procedures. Completes pain and fall assessments as ordered. Communicates changes in pt. condition to supervisor appropriately."

10. By letter dated January 5, 2004, Elliot Hochberg, the Board's enforcement manager responded to an inquiry by respondent as to why she had not yet received her license. Mr. Hochberg wrote that on February 6, 2003, the Board's licensing unit had sent respondent a letter advising her that the Board was unable to continue processing respondent's application until a transcript with the clinical portion of her training from the nursing school respondent had attended had been received. He indicated the transcript had not been received. In addition, he noted that a complaint had been made against respondent while she was working as an "Interim Permittee" and that no license could be issued until there was a final decision regarding the complaint.

11. By letter dated April 21, 2004, Kathy Hodge, a licensing analyst for the Board, notified respondent that her nursing education did not meet the minimum requirements in psychiatric nursing. Ms. Hodge indicated that theory and practical had to be taken concurrently, and that for respondent to become licensed in California, she had to make up this course in both theory and clinical practice at an accredited school of professional nursing, and upon completion of the course, an official transcript had to be submitted to the Board.

LEGAL CONCLUSIONS

1. Business and Professions Code section 480 provides in part:

(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

. . .

(3) Done any act which if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

2. Business and Professions Code section 2761 provides in part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

3. Business and Professions Code section 2762 provides in part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

4. Cause to deny respondent's application for a registered nurse license pursuant to Business and Professions Code sections 480, subdivision (a)(3), and 2761, subdivision (a)(1), was established by Findings 3, 4, and 5.

5. Cause to deny respondent's application for a registered nurse license pursuant to Business and Professions Code sections 480, subdivision (a)(3), 2761, subdivision (a)(1), and 2762, subdivision (e), was not established. The evidence established that respondent administered Ativan to the patient, but properly charted the administration of the drug. Respondent's mistake was in administering a seventh dose of the drug when the original order called for the administration of only six doses. Respondent's acts do not constitute the making of false, grossly incorrect, grossly inconsistent, or unintelligible entries in the patient's hospital chart.

6. Business and Professions Code section 487 provides:

> *If a hearing is requested by the applicant, the board shall conduct such hearing within 90 days from the date the hearing is requested unless the applicant shall request or agree in writing to a postponement or continuance of the hearing. Notwithstanding the above, the Office of Administrative Hearings may order, or on a showing of good cause, grant a request for, up to 45 additional days within which to conduct a hearing, except in cases involving alleged examination or licensing fraud, in which cases the period may be up to 180 days. In no case shall more than two such orders be made or requests be granted.*

Respondent contends Business and Professions Code section 487, which requires a hearing within 90 days after the request for a hearing was made, was violated and therefore a license should be granted to her. Complainant argues that the language of section 487 is directory and contains no consequence if the Board fails to hold a hearing within 90 days from the request for a hearing.

No appellate decision has been found which discusses the appropriate remedy for an alleged violation of Business and Professions Code section 487.

An unreasonable delay in the investigation, filing or prosecution of an administrative action may result in judicial relief where the applicant can show prejudice as a result of the delay. (See, e.g. *Gates v. Department of Motor Vehicles* (1979) 94 Cal.App.3d 921; see, also, in *Steen v. City of Los Angeles* (1948) 31 Cal.2d 542.)

However, it would appear the most appropriate remedy for a violation of Business and Professions Code section 487 would be to provide an applicant with a prompt hearing, not to grant her application for a license because of any unreasonable delay. Granting a license to an unfit or unqualified applicant simply because a hearing on the application was not held within the statutory period would be wholly inconsistent with the regulatory scheme set forth in the Nursing Practice Act. Section 2725 defines the practice of nursing and in particular

> *means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill. . . .*

Clearly, the public interest would not be served, and indeed might be harmed, if an applicant were granted a license without having the requisite "substantial amount of scientific knowledge of technical skill." Accordingly, respondent's argument must be rejected.

7. Respondent also contends the Board was guilty of laches and for that reason, she ought to be granted a license.

Laches is an equitable defense which requires proof of both an unreasonable delay and prejudice resulting from that delay. The party asserting laches bears the burden of proof. Delay is not a bar unless it works to the disadvantage or prejudice of other parties. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 815.)

Respondent failed to establish any prejudice resulting from any unreasonable delay in the investigation and prosecution of this matter. The charges against respondent were established by documentary evidence. The hospital chart showed respondent administered an unauthorized dose of Ativan and did not contain the required fall documentation, and respondent did not claim otherwise. She recalled the incident and did not suggest there were any witnesses or documents that would have helped her but were not available due to the delay. Without evidence of prejudice, respondent did not establish an affirmative defense of laches.

8. Title 16, California Code of Regulations, section 1445 provides:

(a) When considering the denial of a license under Section 480 of the code, the board, in evaluating the rehabilitation of the applicant and his/her present eligibility for a license will consider the following criteria:

(1) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480 of the code.

(3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (1) or (2).

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.

(5) Evidence, if any, of rehabilitation submitted by the applicant.

The evidence viewed in light of the relevant criteria points to the conclusion that upon completion of educational and other licensing requirements, respondent should be granted a probationary license. Respondent's misconduct in connection with her care and treatment of Mary J. must be considered relatively minor. The patient was not injured by the administration of a seventh dose of Ativan, and as it turns out, the patient's physician ordered

a seventh dose three hours after respondent administered it. While administration of the unauthorized dose of Ativan had the potential for harm, in reality, there was little likelihood the patient would be harmed. Respondent's mistake stemmed from her failure to review the orders, not from any intent to injure the patient. It is a mistake that with proper education and oversight, should not recur, and respondent admitted she made a mistake. The same must be said about respondent's failure to document the risk assessment.

Complainant introduced evidence in aggravation, but it must be noted that such evidence related to respondent's job performance at about the time of the incidents in question. *See* Exhibit 8. There was no evidence respondent committed any acts for which a license could be denied after 2002. It must also be noted that respondent's job performance at Sharp, while below expectations, resulted in a denial of a pay increase, but did not cause Sharp to terminate her employment, which suggests Sharp did not consider respondent's job performance unacceptable.

Five years have elapsed since respondent administered the unauthorized dose of Ativan and failed to perform the required fall assessments. Since then, respondent has worked in other hospitals, and received a license as a registered nurse in Missouri. She appears to work satisfactorily at her current position.

Based upon the foregoing, it would not be against the public interest to grant respondent's application for license and allow her to practice nursing on probation. A period of three years on probation would be an appropriate period of time to allow the Board to monitor respondent's job performace.

ORDER

The application of respondent Ubah Ahmed Mindigall for licensure is granted. Upon successful completion of all licensing requirement, a license shall be issued to respondent. Said license shall immediately be revoked, the order of revocation stayed and respondent placed on probation for a period of three years on the following conditions:

Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

(1) OBEY ALL LAWS. Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by the respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

CRIMINAL COURT ORDERS. If respondent is under criminal court orders, including probation or parole, and the order is violated, this shall be deemed a violation of these probation conditions, and may result in the filing of an accusation and/or petition to revoke probation.

(2) COMPLY WITH THE BOARD'S PROBATION PROGRAM. Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

Upon successful completion of probation, respondent's license shall be fully restored.

(3) REPORT IN PERSON. Respondent, during the period of probation, shall appear in person at interviews/meetings as directed by the Board or its designated representatives.

(4) RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE. Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

(5) SUBMIT WRITTEN REPORTS Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which he or she has a registered nurse license.

(6) FUNCTION AS A REGISTERED NURSE. Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a

minimum of 24 hours per week for six consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for six consecutive months or as determined by the Board.

If respondent has not complied with this condition during the probationary term, and the respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

(7) EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS. Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

(8) SUPERVISION. Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum. The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate. The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum. The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care. If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the respondent with or without respondent present.

(9) EMPLOYMENT LIMITATIONS. Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If the respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

(10) COMPLETE A NURSING COURSE(S). Respondent, at her own expense, shall enroll and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to respondent after photocopying them for its records.

(11) VIOLATION OF PROBATION. If respondent violates the conditions of her probation, the Board after giving respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of the respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's office has been requested to prepare an accusation or petition to revoke probation against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

(12) LICENSE SURRENDER. During respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender his or her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

(1) Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or
(2) One year for a license surrendered for a mental or physical illness.

DATED: 6/29/07

ALAN S. METH
Administrative Law Judge
Office of Administrative Hearings

BILL LOCKYER, Attorney General
of the State of California
RITA M. LANE, State Bar No. 171352
Lead Supervising Deputy Attorney General
California Department of Justice
110 West "A" Street, Suite 1100
San Diego, CA 92101

P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2614
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against: **UBAH AHMED MINDINGALL** 38936 Wondering Lane Murrieta, CA 92563 Applicant.	Case No. 2007-22 **STATEMENT OF ISSUES**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Statement of Issues solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 26, 2001, the Board of Registered Nursing ("Board"), Department of Consumer Affairs, received an Application for RN Licensure by Endorsement from Ubah Ahmed Mindingall ("Applicant"). On or about June 10, 2001, Applicant certified under penalty of perjury to the truthfulness of all statements, answers, and representations in the application. The Board denied the application on August 4, 2004.

///

///

JURISDICTION

3. Section 2736 of the Business and Professions Code ("Code") provides, in pertinent part:

> (a) An applicant for licensure as a registered nurse shall comply with each of the following:
>
> (3) Not be subject to denial of licensure under Section 480.

STATUTORY PROVISIONS

4. Code section 480 provides, in pertinent part:

> (a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:
>
> (3) Done any act which if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

5. Code section 2761 provides:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

6. Code section 2762 provides, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

///

///

///

///

7. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

8. California Code of Regulations, title 16, section 1442, provides:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

DRUGS

9. "Ativan" is brand of lorazepam, a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(12), and a dangerous drug within the meaning of Code section 4022.

Background

10. On or about May 16, 2003, the Board received a complaint alleging that Applicant had entered false and misleading information in a patient's medical records, and had administered an unauthorized dose of Ativan to the same patient while employed at Sharp Memorial Hospital, located at 7901 Frost Street, San Diego, California, under a temporary

///

///

///

///

registered nurse's license issued pursuant to Code section 2733.[1] That license expired on September 30, 2003.

11. The Board's investigation disclosed that on or about March 12, 2002, Patient M. B. J. was admitted to Sharp Memorial Hospital for right knee replacement surgery. Following surgery, Patient M. B. J. was assigned to Applicant's unit, 9 North Unit, for post-operative care. On the patient's arrival, Applicant failed to prepare a Schmid Fall Risk Assessment on the patient.

12. On or about March 15, 2002, at approximately 0830 hours, Applicant documented that she obtained and administered one dose of Ativan to Patient M. B. J. Applicant's administration of Ativan to Patient M. B. J. was in contravention of physician's orders directing that the administration of Ativan to M. B. J. be discontinued after 0100 hours, March 15, 2002. Applicant did not document or record that authority had been obtained from M. B. J.'s physician for the 0830 hours administration of Ativan.

GROUNDS FOR DENIAL OF LICENSURE

(Acts as Grounds for Suspension or Revocation of a License)

13. Grounds exist to deny the application of Applicant under Code sections 2736 and 480, subdivision (a)(3), for the commission of the following acts which if committed by a licensed registered nurse would have subjected that license to suspension or revocation:

---

1. Code section 2733 provides:

> (a) Upon approval of an application filed pursuant to subdivision (b) of Section 2732.1, and upon the payment of the fee prescribed by subdivision (k) of Section 2815, the board may issue a temporary license to practice professional nursing, and a temporary certificate to practice as a certified nurse midwife, certified nurse practitioner, certified public health nurse, certified clinical nurse specialist, or certified nurse anesthetist for a period of six months from the date of issuance.
>
> (b) Upon written application, the board may reissue a temporary license or temporary certificate to any person who has applied for a regular renewable license pursuant to subdivision (b) of Section 2732.1 and who, in the judgment of the board has been excusably delayed in completing his or her application for or the minimum requirements for a regular renewable license, but the board may not reissue a temporary license or temporary certificate more than twice to any one person. (Bus. & Prof. Code, § 2733, subds. (a) & (b).)

a. **Gross Negligence**.

1. On or about March 12, 2002, Applicant failed to prepare a Schmid Fall Risk Assessment AND A POST-FALL ASSESSMENT DSM 4/30/02 on Patient M. B. J. The foregoing act, if committed by a licensed registered nurse, would have subjected that license to suspension or revocation for unprofessional conduct under Code sections 2761, subdivision (a), as defined under 2762, subdivisions (a)(1), as an act of gross negligence.

2. On or about March 15, 2002, at approximately 0830 hours, Applicant obtained and administered one dose of Ativan, a controlled substance and a dangerous drug, to Patient M. B. J. in contravention of physician's orders directing that the administration of Ativan be discontinued after 0100 hours, March 15, 2002. The foregoing act, if committed by a licensed registered nurse, would have subjected that license to suspension or revocation for unprofessional conduct under Code sections 2761, subdivision (a), as defined under 2762, subdivisions (a)(1), as an act of gross negligence.

b. **False, Grossly Incorrect, Grossly Inconsistent, or Unintelligible Record Entries**.

On or about March 15,2002, at approximately 0830 hours, Applicant documented that she had obtained and administered one dose of Ativan, a controlled substance and a dangerous drug, to Patient M. B. J. Thereafter, Applicant failed to record or document that authority for 0830 hours administration of Ativan to M. B. J. had been obtained from the patient's physician. The foregoing act, if committed by a licensed registered nurse, would have subjected that license to suspension or revocation for unprofessional conduct under Code section 2761, subdivision (a), as defined under 2762, subdivisions (e), as making false, grossly incorrect, grossly inconsistent, or unintelligible entries in a hospital, patient, or other record pertaining to a controlled substance.

FACTORS IN AGGRAVATION

For consideration in determining whether Applicant should be issued a license, Complainant alleges that on or about May 2002, Sharp Memorial Hospital made a Developmental Plan for Applicant, outlining areas for improvement in Applicant's practice.

Applicant continued to make errors in the areas outlined in the Developmental Plan and on October 1, 2002, Applicant received formal corrective action from Sharp Memorial Hospital and a four page written warning related to Applicant's continuation of nursing errors resulting in unsafe patient care. Examples of Applicant's nursing errors that resulted in unsafe patient care are failing to dispense medication to patients; failing to make charting notes in patient charts; giving medication to patients when not ordered; giving medication and not noting it in the patient charts; failing to assess a patient at all during a shift; and giving the wrong narcotic drug to a patient.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Denying the Application for RN Licensure by Endorsement of Ubah Ahmed Mindingall; and,

2. Taking such other and further action as deemed necessary and proper.

DATED: 7/18/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

03579110-SD2005700465
10214100.wpd